

104 CMR 29.00: SERVICE PLANNING

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29.01: Legal Authority, Scope and Purpose

- (1) Legal Authority. 104 CMR 29.00 is promulgated under authority of M.G.L. c. 19, §§1 and 16, and M.G.L. c. 123, §2.
- (2) Scope. 104 CMR 29.00 applies to the initiation and provision of DMH continuing care services to clients in community programs and services that are contracted for or operated by the Department of Mental Health.
- (3) Purpose. 104 CMR 29.00 is issued to provide a framework by which DMH continuing care services are provided in the community to adults with serious and long term mental illness and children and adolescents with serious emotional disturbance.

29.02: Definitions

Case Management means a service operated by the Department, which shall be performed in accordance with the provisions of 104 CMR 29.00. The scope of case management services is set forth at 104 CMR 29.05.

Client means an individual who has been determined to be eligible for DMH continuing care services by the Department and who receives DMH continuing care services.

DMH Continuing Care Services means community-based services contracted for or operated by the Department, but which do not include: services of brief duration, outpatient services, court evaluations, or acute mental health services, such as crisis intervention or emergency screening.

Day means Monday through Friday, excluding any legal holidays.

29.03: General Provisions

- (1) The Department is responsible for providing or arranging for DMH continuing care services to adults with serious and long term mental illness and children and adolescents with serious emotional disturbance who are determined eligible and are prioritized for such services.
- (2) Services will be provided to individuals who have been determined eligible for DMH continuing care services subject to the availability of services, funding, and the Department's determination of the priority of an individual's need for services.
- (3) The goal of service planning activities is to:
 - (a) identify the full range of services that a client needs;

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- (b) facilitate or provide access to those services; and
 - (c) ensure that the provision of DMH continuing care services is consistent with the client's needs and preferences and provided in the least restrictive setting possible.
- (4) Participation in Treatment Planning.
- (a) All clients, including those who have a legally authorized representative, shall be given the opportunity to participate in and contribute to their individual service planning to the maximum extent possible.
 - 1. The client shall be present at the service and treatment planning and review meetings outlined in 104 CMR 29.00 unless the client is unwilling or unable to attend.
 - 2. The client shall be encouraged to identify and discuss his or her goals and preferred services and programs during these meetings and shall otherwise be supported to participate in a meaningful way in the discussions and decision-making process.
 - (b) When a client is unable or unwilling to take part in a meaningful way in the service planning process, the case manager, with the assistance of the treatment team, shall take steps to minimize obstacles to participation in service planning activities. This shall include but not be limited to:
 - 1. developing a plan for increasing the ability of the client to participate;
 - 2. modifying the schedule or structure of the meetings or making other accommodations designed to increase the client's participation;
 - 3. educating the client in order to facilitate and increase his or her participation; and
 - 4. continuing to engage the client in ways that assist him or her to make choices regarding his or her care and treatment to the maximum extent possible.
- (5) Individuals requesting community-based mental health services from the Department shall be informed of:
- (a) the right to apply for DMH continuing care services;
 - (b) the authority of the Department to require necessary and relevant information about the individual's needs and resources, including access to entitlements, insurance and other services;
 - (c) the right to participate in and contribute to their individual service planning as set forth in 104 CMR 29.03(4);
 - (d) the authority of the Department or its providers to charge for and, if applicable, adjust charges for services;
 - (e) the right to appeal denial of eligibility for DMH continuing care services based on clinical criteria in accordance with 104 CMR 29.15(3);
 - (f) the right to appeal denial of eligibility for DMH continuing care services based on need for services and individual service planning and implementation decisions in accordance with 104 CMR 29.15(4);
 - (g) the authority of the Department to maintain the name of the individual and other personal information in a confidential record keeping system, including by electronic means.
- (6) All information pertaining to the service planning process pursuant to 104 CMR 29.00, including notifications, comprehensive assessment of needs, individual service plan, and program specific treatment plans, shall be written in language that is easy to understand.

29.04: Eligibility for DMH Continuing Care Services

- (1) To be eligible to receive DMH continuing care services, an individual must meet the clinical criteria set forth in 104 CMR 29.04(3), and be determined to be in need of DMH continuing care services pursuant to 104 CMR 29.04(4).
- (2) Application for Eligibility for DMH Continuing Care Services.
 - (a) An application for eligibility for DMH continuing care services for an individual shall be submitted to the Area Office with responsibility for the community where the individual or, in the case of a minor, his or her legally authorized representative resides.
 - (b) An application may be submitted by:
 - 1. An individual or his or her legally authorized representative, if any. An individual may be assisted by another person in completing the application.

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2. A facility or program on behalf of an individual, if
 - a. the individual, after being notified, does not object to the submission of an application; or
 - b. the facility or program believes an individual to be incapable and has filed a petition with the court for guardianship for the individual.
 - (c) An application shall include the following:
 1. completed application form;
 2. supporting documentation of psychiatric evaluations and clinical records that are available to the applicant. The individual or his or her legally authorized representative, if any, may be asked to permit the Department to obtain additional information which it deems necessary to support the application.
 - (d) The Department may, at its discretion, require a personal interview or a clinical evaluation, or both, of the individual in order to gather additional information to support the application.
 - (e) If, during the application process, the Area Director or designee determines that the individual is in need of short-term services, the individual may be authorized for such services for up to 60 days. During this period, the individual's application is considered "pending eligibility." Provision of such services is not an indication of whether or not an application will be approved.
- (3) Clinical Criteria for DMH Continuing Care Services.
- (a) To meet the clinical criteria to be eligible to receive DMH continuing care services, an adult must have a mental illness that:
 1. includes a substantial disorder of thought, mood, perception, orientation or memory which grossly impairs judgment, behavior, capacity to recognize reality or the ability to meet the ordinary demands of life; and
 2. has lasted, or is expected to last, at least one year; and
 3. has resulted in functional impairment that substantially interferes with or limits the performance of one or more major life activities, and is expected to do so in the succeeding year; and
 4. meets diagnostic criteria specified within the current edition of *Diagnostic and Statistical Manual of Mental Disorders*, which indicates that the individual has a serious, long term mental illness that is not based on symptoms primarily caused by substance related disorders, mental retardation or organic disorders due to a general medical condition not elsewhere classified.
 - (b) To meet the clinical criteria to be eligible to receive DMH continuing care services, a child or adolescent must be under 19 years of age at the time of application and have a serious emotional disturbance that:
 1. has lasted, or is expected to last, at least one year; and
 2. has resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school or community activities; and
 3. meets diagnostic criteria specified within the current edition of *Diagnostic and Statistical Manual of Mental Disorders*, but is not solely within one or more of the following categories:
 - a. developmental disorders usually first diagnosed in infancy, childhood or adolescence, such as mental retardation; or
 - b. cognitive disorders, including delirium, dementia or amnesia; or
 - c. organic disorders due to a general medical condition not elsewhere classified; or
 - d. substance-related disorders.
 - (c) If an individual does not meet the clinical criteria set forth in 104 CMR 29.04(3)(a) or (b) a notice denying the application for eligibility will be sent to the individual and his or her legally authorized representative, if any, and the facility or program that submitted the application, if any. The notice shall set forth the reasons for the denial of the application. The individual and his or her legally authorized representative, if any, shall be informed of the right to appeal the denial based on clinical criteria pursuant to 104 CMR 29.15(3). The individual may reapply for eligibility at a later date, if the individual's clinical circumstances change.

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(4) Need for DMH Continuing Care Services. If an individual is found to meet the clinical criteria for eligibility, the Area Director or designee will make a determination as to whether the individual requires DMH continuing care services in order to be appropriately served in the community. This will be based on the following:

- (a) contact with the applicant and his or her legally authorized representative, if any, to review the applicant's request for services and his or her current status;
- (b) determination of whether the individual's needs are such that he or she requires a DMH continuing care service;
- (c) assessment of the individual's current medical entitlements and/or insurance that allow for provision of appropriate services in the community;
- (d) assessment of the availability of appropriate services from other public or private entities.

(5) Results of Eligibility Determination.

(a) The Area Director or designee will have 20 days from the date of the completed application, including personal interviews and clinical evaluations, to render a decision on the application.

(b) Denial of Application for Eligibility Based on Clinical Criteria. If the individual does not meet the clinical criteria for eligibility, notice will be provided as outlined in 104 CMR 29.04(3)(c).

(c) Denial of Application for Eligibility Based on Need for DMH Continuing Care Services.

1. The application for eligibility for an individual who has been determined to meet the clinical criteria will be denied if it is determined that the individual's needs are such that he or she does not require a DMH continuing care service or that medical coverage or other public or private services are available at the time of the application which can meet the individual's needs.

2. If the application for eligibility is denied, a notice will be sent to the individual and his or her legally authorized representative, if any, and the facility or program which submitted the application, if any. The notice shall set forth the reasons for the denial of the application. The individual and his or her legally authorized representative, if any, shall be informed of the right to appeal the denial of eligibility for DMH continuing care services based on need pursuant to 104 CMR 29.15(4). The individual and his or her legally authorized representative shall also be informed, if appropriate, of other community services that may be available to meet his or her needs.

3. If an individual whose application is denied based on lack of need for DMH continuing care services reapplies due to a change in circumstances within six months of such denial, he or she shall be presumed to continue to meet the clinical criteria for DMH continuing care services.

(d) Approval of Application for Eligibility Based on Need for DMH Continuing Care Services.

1. An application for eligibility for a person who meets the clinical criteria will be approved if it is determined that the individual's needs are such that he or she requires a DMH continuing care service and that no medical coverage or other public or private services are available that can provide for appropriate services in the community.

2. If it is determined that coverage or services are available that can provide for some but not all of the appropriate services for the individual, the Area Director or designee will determine the individual to be eligible for DMH continuing care services limited to those services that are not available elsewhere.

(e) Determination of Priority Status. If an application for eligibility is approved, the Area Director or designee shall make a determination of the individual's priority for DMH continuing care services, based on the current severity of need, the individual's circumstances, and the availability of services.

1. Client status. If the Area Director or designee determines that the individual has a high priority for services and some or all of the needed DMH continuing care services are immediately available, the individual will be placed on client status.

2. Pending services status. If the Area Director or designee determines that the individual has a high priority for services but none of the needed services is immediately available, the individual will be placed on pending services status.

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3. Low-priority status. If the Area Director or designee determines that the individual does not have a high priority for services, relative to other individuals who were placed on client or pending services status, and DMH services are not available, or expected to become available within a year or more, to meet his or her needs, the individual will be placed on low-priority status.
- (f) Notification of Eligibility and Action on Status. If an application for eligibility has been approved, the Area Director will notify the individual and his or her legally authorized representative, if any, and the facility or program which submitted the application on the individual's behalf pursuant to 104 CMR 29.04(2)(b)2., if any, that the application for eligibility has been approved and what priority status the individual has been assigned. If the individual has been placed on low-priority status, he or she will be informed, if appropriate, of other community services that may be available to meet some of his or her needs.
 1. If the individual is placed on client status, the Area Director or designee will assign the individual, within five days, to a case manager, pursuant to 104 CMR 29.05. The case manager shall provide service planning activities pursuant to 104 CMR 29.06. If some or all of the services are available but a case manager is not available, the individual will receive the available services pending assignment to a case manager for service planning. In the interim, the service provider(s) shall prepare a program specific treatment plan pursuant to 104 CMR 29.07. When an individual is either assigned to a case manager or is receiving services pursuant to this paragraph, he or she will be a DMH client.
 2. If the individual has been placed on pending services status, the Area Director or designee will regularly contact the applicant regarding his or her status, until some or all of the services become available, at which time the provisions of 104 CMR 29.04(5)(e)1. and (f)1. will apply.
 3. The names of individuals on low-priority status will be maintained by the Area Office, but will not be in any ranked order. The Area Director will periodically review the listing for continued eligibility and changes in prioritization. If the Area Director determines that the priority of an individual on low-priority status should change because of changes in his or her current severity of need, individual circumstances, and the availability of needed services, the Area Director may place the individual on either client status or pending services status pursuant to 104 CMR 29.04(5)(e).
- (g) Initial decisions regarding priority status and decisions regarding changes in priority from low-priority or pending services status to a higher priority status are at the discretion of the Area Director or designee, based on his or her current judgment regarding assessment of severity of need, individual circumstances, and available resources, and are not subject to appeal pursuant to 104 CMR 29.15.

29.05: Case Management Services

- (1) When an individual has been determined eligible and some or all of the needed DMH continuing care services are available, he or she will be assigned a case manager. If a case manager is not immediately available, such assignment shall take place as soon as possible thereafter.
- (2) Case management services shall include:
 - (a) arranging for and completing the comprehensive assessment of client needs;
 - (b) convening the service planning meeting;
 - (c) developing and reviewing the individual service plan;
 - (d) reviewing the program specific treatment plan(s) to ensure each client's program specific treatment plan(s) is (are) compatible with the client's individual service plan;
 - (e) coordinating services to the client, and/or monitoring the coordination of DMH continuing care services provided to a client, as determined by the Area Director or designee.
- (3) In addition to the services identified in 104 CMR 29.05(2), case management services may include the following, as determined by the Area Director or designee:
 - (a) assisting the client to obtain other services, in addition to DMH continuing care services, that are identified in the client's individual service plan but are available from other public or private entities;

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- (b) providing outreach, as needed;
- (c) providing intensive support and advocacy, as needed.

29.06: Service Planning

(1) Comprehensive Assessment of Service Needs.

- (a) The case manager shall arrange for and complete a comprehensive assessment of the client's service needs within 20 days of assignment, unless an extension is granted by the Area Director or designee.
- (b) The comprehensive assessment of service needs shall include review of the documents submitted with the client's application and other records, as needed; a personal interview with the client; an interview with the client's legally authorized representative, if any; and interviews with other persons as agreed upon by the case manager and the client or his or her legally authorized representative, if any.
- (c) The comprehensive assessment of service needs shall consider the following areas, based on the client's circumstances, consultation with service providers, use of a functional assessment tool approved by the Department, and the availability of information:
 - 1. Mental status exam;
 - 2. Psychiatric needs:
 - a. past psychiatric conditions and response to treatment;
 - b. substance abuse history and treatment;
 - c. need for psychiatric inpatient services.
 - 3. Risk assessment;
 - 4. Family and other personal supports;
 - 5. Parental and other family obligations;
 - 6. Home environment;
 - 7. Availability of government benefits;
 - 8. Health insurance status;
 - 9. Health needs:
 - a. review of medical history and determination of active medical problems;
 - b. availability of primary care physician;
 - c. review of dental history and needs;
 - d. availability of dentist;
 - e. date of last annual physical and dental exam.
 - 10. Daily living skills;
 - 11. Criminal and juvenile justice history;
 - 12. Vocational and employment history and skills;
 - 13. Education and training;
 - 14. Religious, language and cultural preferences;
 - 15. Need for guardian;
 - 16. Need for financial fiduciary, including an assessment of the client's ability to manage and spend his or her own funds;
 - 17. Services provided by or available from other agencies or entities.
- (d) The case manager shall prepare a comprehensive assessment of service needs report, which shall include the following:
 - 1. the client's strengths;
 - 2. the client's needs;
 - 3. the preferences of the client and his or her legally authorized representative, if any; and
 - 4. recommendation of services that meet the client's needs.
- (e) After an individual has been placed on client status, the Area Director or designee may authorize short term services for the client during the time the comprehensive assessment of needs is being completed. Provision of these services is not an indication that these services will be included in the client's individual service plan.

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(2) Development of Individual Service Plans.

(a) General Provisions.

1. The individual service plan shall identify the strengths and needs of the client, the goals of and for the client, and all services and programs which address the needs of the client, including DMH continuing care services and those available from other public and private entities.
2. Services shall be, to the maximum extent possible, consistent with the client's service needs and preferences, and provided in the least restrictive setting.
3. The individual service plan shall be developed with the fullest possible coordination with the client's Individual Education Program, where appropriate.
4. For DMH continuing care services, the individual service plan shall specify services, programs, service providers and goals based on:
 - a. the client's needs and preferences as identified in the comprehensive assessment of service needs report; and
 - b. the availability of specific services. If specified services are not available, the individual service plan shall detail other available services which are, to the maximum extent possible, consistent with the client's needs and preferences and provided in the least restrictive setting.
5. In developing the individual service plan, the case manager shall try to informally resolve any differences that may occur between service providers. If the case manager is unable to informally resolve any such differences, within five days after identification of the dispute, the Area Director or designee shall be notified of the need for intervention.

(b) Preparation of the Individual Service Plan.

1. Within ten days of the completion of the comprehensive assessment of service needs report, the case manager shall convene a meeting of all interested parties to prepare the individual service plan. Persons invited to attend the meeting shall include:
 - a. the client;
 - b. the client's legally authorized representative, if any;
 - c. current and potential service providers;
 - d. other Department staff;
 - e. any other persons, including family members, whose participation is requested or consented to by the client or the client's legally authorized representative, if any.
2. At the individual service plan meeting the parties shall discuss the following, which shall be included in the written individual service plan:
 - a. the goals for the client;
 - b. the preferences of the client and the client's legally authorized representative, if any, regarding services;
 - c. the client's needs in the context of his or her assessed strengths;
 - d. recommended services for the client;
 - e. currently available services, including those provided by or available from other agencies or entities;
 - f. potential and present service providers;
 - g. dates, actual or anticipated, for commencement of each service;
 - h. the steps necessary to complete and implement the individual service plan, including the development of its component program specific treatment plans;
 - i. a description of the financial assistance and services from federal, state and local agencies available to the client, including any benefits to which the client may be entitled but is not currently receiving;
 - j. the client's need for a guardian, or a financial fiduciary.

(c) Authorization for DMH continuing care services shall be obtained from the Area Director or designee at the end of the individual service plan meeting and prior to a request to each service provider for a program specific treatment plan pursuant to 104 CMR 29.07.

(d) After authorization for DMH continuing care services is obtained, a preliminary individual service plan will be sent to the service providers and the client and his or her legally authorized representative, if any. Such plan shall state the overall general goals and strategies anticipated for the completed individual service plan.

29.07: Development of the Program Specific Treatment Plan

- (1) Each service provider authorized to provide DMH continuing care services to the client shall, within ten days of authorization, meet with the client and his or her legally authorized representative, if any, to determine the goals and objectives which will form the basis of the program specific treatment plan.
- (2) Each service provider providing DMH continuing care services shall, within 20 days of the individual service plan meeting, develop and prepare a written program specific treatment plan for the client, and submit it to the case manager for inclusion in the individual service plan.
- (3) Content of Program Specific Treatment Plan. The program specific treatment plan shall be based on those findings of the application process and the comprehensive assessment of service needs that are relevant to the program and shall include to the extent possible the following:
 - (a) long-range goals and short-term treatment objectives stated in specific and measurable terms with timelines;
 - (b) specific treatment modalities to be utilized.
- (4) If, pursuant to 104 CMR 29.04(5)(f)1., an individual is receiving services, but a case manager has not yet been assigned, the program specific treatment plan shall be completed within 20 days of service authorization and shall be submitted to the Area Director or designee.

29.08: Integration of the Individual Service Plan with Program Specific Treatment Plans

- (1) The case manager shall ensure that each DMH continuing care service provider formulates a program specific treatment plan in accordance with the standards for program specific treatment plans set out in 104 CMR 29.07.
- (2) The case manager shall ensure that each program specific treatment plan is compatible with the goals of the individual service plan and the client's other program specific treatment plans.
- (3) If, during the development of the individual service plan or the program specific treatment plans, additional evaluations are necessary which are beyond a service provider's capability to perform, the case manager shall be notified, and a request shall be brought to the Area Director or designee for authorization to have such evaluations performed.
- (4) Within 25 days of the individual service plan meeting, the case manager shall prepare a written individual service plan, attaching and including as part of the plan the program specific treatment plan(s) prepared pursuant to 104 CMR 29.07.

29.09: Acceptance or Rejection of the Individual Service Plan

- (1) Once the written individual service plan is complete, it shall be sent to the client or his or her legally authorized representative, if any, for acceptance or rejection.
 - (a) Upon acceptance by the client, or his or her legally authorized representative, if any, the individual service plan shall be implemented.
 - (b) If the client or his or her legally authorized representative, if any, does not object to the individual service plan within 20 days of the date when the individual service plan was received, he or she shall be deemed to have accepted the individual service plan.
 - (c) If the client, or his or her legally authorized representative, if any, rejects some or all of the services identified in the individual service plan, the case manager shall inform him or her of the right to meet with the case manager within five days of the rejection to discuss the individual service plan and to discuss possible modifications.
 - (d) If agreement regarding any such modifications is not reached and the client or his or her legally authorized representative, if any, continues to reject the proposed plan, he or she may appeal the service plan pursuant to 104 CMR 29.15.
- (2) The parts of the individual service plan that are accepted by the client or the client's legally authorized representative, if any, may be implemented immediately, if appropriate.

29.10: Annual Review of the Individual Service Plan

(1) No later than 12 months from the date of the last completed or substantially modified individual service plan, the case manager shall initiate a review of the client's individual service plan and its component program specific treatment plans.

(a) The purpose of this review is to ensure that:

1. services continue to be, to the maximum extent possible, consistent with the client's needs and preferences, and provided in the least restrictive setting; and
2. program specific treatment plans continue to be consistent with the individual service plan.

(b) At least 15 days prior to the date of the annual review, the case manager shall contact the following persons:

1. the client;
2. the client's legally authorized representative, if any;
3. a representative of each of the client's service providers;
4. other Department staff;
5. any other persons, including family members, whose participation is requested by or consented to by the client or the client's legally authorized representative, if any.

(2) The case manager shall inform each person contacted of the proposed meeting to discuss the review of the individual service plan, and shall schedule the meeting at a time convenient to all persons. If all persons are in agreement, the meeting can be waived.

(3) At the meeting or, if a meeting has been waived, by other means, the case manager shall consider and also inquire of each person:

- (a) whether the client continues to meet the criteria for eligibility for DMH continuing care services pursuant to 104 CMR 29.04(3) and (4);
- (b) whether any change in the client's circumstances is such that he or she should be considered for change from client status to a lower priority status;
- (c) whether any change in the client's circumstances should result in a modification of his or her priority of need for services not currently provided;
- (d) whether the services being provided to the client continue to be consistent with his or her needs and the goals of the individual service plan;
- (e) whether there has been progress toward attainment of goals and objectives stated in the component program specific treatment plans;
- (f) whether there has been any change in the prior determination as to need for a guardian or a financial fiduciary.

(4) Each service provider shall be required to submit a new program specific treatment plan to the case manager no later than ten days after the annual review meeting, or a date set by the case manager if the meeting is waived.

(5) Completion of Individual Service Plan after the Annual Review.

(a) Within ten days after the annual review meeting or date set by the case manager if the meeting is waived, the case manager shall prepare an individual service plan, and shall include the new program specific treatment plans submitted by the DMH continuing care service providers.

(b) Once the individual service plan is completed, the case manager shall seek continued authorization for services from the Area Director or designee.

(c) Once services are authorized, the case manager shall send the individual service plan to the client or his or her legally authorized representative, if any, for acceptance or rejection.

1. Upon acceptance by the client, or his or her legally authorized representative, if any, the individual service plan shall be implemented.
2. If the client or his or her legally authorized representative, if any, does not object to the individual service plan within 20 days of the date when the individual service plan was received, he or she shall be deemed to have accepted the service plan.

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3. If the client or his or her legally authorized representative, if any, rejects some or all of the individual service plan, he or she shall be informed of the right to meet with the case manager within five days of the rejection to discuss the individual service plan and to discuss any changes. He or she shall also be informed of the right to appeal the individual service plan, pursuant to 104 CMR 29.15. The parts of the individual service plan that are accepted by the client or the client's legally authorized representative, if any, may be implemented immediately, if appropriate.
- (d) If at the time of the annual review, questions arise as to whether the client continues to meet the criteria for eligibility for DMH continuing care services or should remain on priority status as a client, the client will be referred for redetermination, pursuant to the provisions of 104 CMR 29.04. Action on any such redetermination shall be subject to the procedures in 104 CMR 29.04 and 104 CMR 29.12 or 29.13, as applicable, and shall be subject to appeal pursuant to 104 CMR 29.15.

29.11: Modification of the Individual Service Plan or Program Specific Treatment Plan

- (1) Requests for modification of an individual service plan, a program specific treatment plan or services, or for a change in service provider(s), may be initiated by the client, his or her legally authorized representative, if any, the client's service provider(s), or the client's case manager.
- (2) Modifications shall be made in an individual service plan, a program specific treatment plan, or service provider(s) whenever it is determined at an annual review or at any other time, in accordance with the service planning procedures required by 104 CMR 29.00, that such a change will permit the client to receive more appropriate or less restrictive treatment consistent with the client's needs or that the client no longer needs a service or services.
- (3) No modification of an individual service plan, a program specific treatment plan, services, or service providers shall be made without the acceptance of the client or his or her legally authorized representative, if any, and the service provider(s) involved, unless it is determined that the modification is required:
 - (a) to comply with state contracting requirements (*i.e.*, that compliance with state purchase of service regulations or other applicable contracting requirements requires a change in a service provider); or
 - (b) to avoid a serious or immediate threat to the health, mental health or safety of the client or other persons.
- (4) The client or his or her legally authorized representative, if any, may reject and appeal a proposed or denied modification pursuant to 104 CMR 29.15. No modification under appeal may be implemented before the appeal is decided, without the consent of the client, or his or her legally authorized representative, if any, unless it is determined that the modification is required for the reasons outlined in 104 CMR 29.11(3)(a) or (b).
- (5) Clients in residential programs may have additional remedies, including the protections enumerated under the Community Residence Tenancy Law, St. 1995, c. 38, § 308.
- (6) If the modification involves a substantial change in the client's situation, e.g., change from a group residential program to independent living, as determined by the case manager, the modification may follow the procedures outlined in 104 CMR 29.10, and serve as the client's annual review. In such case, the date of the next annual review shall be calculated from the date of acceptance of the modified plan. If the modification is minor, as determined by the case manager, the individual service plan will be reviewed no later than 12 months from the last time the individual service plan was completed or reviewed.

29.12: Changes in Status to Lower Priority

- (1) If at the annual review or at any other time, there is reason to believe that a client or an individual on pending services status should no longer be considered a high priority for services, the individual will be referred to the Area Director or designee for a redetermination of priority.

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- (2) If the Area Director or designee determines that the individual should be moved to low-priority status, he or she shall:
 - (a) notify the individual and his or her legally authorized representative, if any, of the basis for changing priority and, if the individual is a client, the date that DMH continuing care services will end;
 - (b) notify the individual and his or her legally authorized representative, if any, of the right to appeal change in status to a lower priority pursuant to 104 CMR 29.15;
 - (c) if the individual is a client, modify his or her individual service plan to indicate the termination of DMH continuing care services and move to lower priority status;
 - (d) If the individual is a client, the Department will, for 30 days after the date that DMH continuing care services end, continue to monitor the individual to determine that he or she is connected to appropriate services, as necessary. At the conclusion of that 30 day period the individual will no longer be a client.
- (3) If an appeal is filed pursuant to 104 CMR 29.15, priority status shall not change and, if the individual is a client, services shall not be terminated until the appeal is completed.

29.13: Termination of Eligibility for DMH Continuing Care Services

- (1) If there is reason to believe that a client or an individual on pending services or low-priority status is no longer eligible for DMH continuing care services, either because he or she no longer meets the clinical criteria in 104 CMR 29.04(3) or no longer needs DMH continuing care services pursuant to 104 CMR 29.04(4), as determined by the annual review of the individual service plan, review of individuals on pending services and low-priority status, or at any other time, the individual will be referred for a redetermination of eligibility pursuant to 104 CMR 29.04. If, after the redetermination, the individual is found to no longer meet the criteria for eligibility for DMH continuing care services, the matter will be referred to the Area Director or designee for review.
- (2) If the Area Director or designee agrees that the individual no longer meets the criteria for eligibility for DMH continuing care services, a date will be set for the termination of eligibility. The Area Director or designee shall:
 - (a) notify the individual and his or her legally authorized representative, if any, of the basis for terminating eligibility and, if the individual is a client, the date that DMH continuing care services will end;
 - (b) notify the individual and his or her legally authorized representative, if any, of the right to appeal termination of eligibility for continuing care services based on clinical criteria pursuant to 104 CMR 29.15(3) or based on need for DMH continuing care services pursuant to 104 CMR 29.15(4);
 - (c) if the individual is a client, modify his or her individual service plan to indicate the termination of DMH continuing care services and eligibility;
 - (d) identify and state on the individual service plan the name and address of the agency or person, if any, responsible for the provision of future services to the individual, or state that no further services are currently needed.
- (3) If an appeal is filed pursuant to 104 CMR 29.15, eligibility shall not be terminated and, if the individual is a client, services shall not be terminated until the appeal is completed.
- (4) If the individual is a client, the Department will, for 30 days after the date that DMH continuing care services end, continue to monitor the individual to determine that he or she is connected to appropriate services, as necessary. At the conclusion of that 30 day period the individual will no longer be a client.

29.14: Requests for Termination of Services; Disengagement from Services

- (1) If a client, or his or her legally authorized representative, if any, requests termination of the client's DMH continuing care services, the request will be referred to the Area Director or designee for review.

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- (a) If the Area Director or designee concurs with the request, then services shall be terminated and the individual will no longer be a client.
 - (b) If such request is against the advice of the Area Director or designee, he or she shall make efforts, for a period of up to 30 days, to persuade the client or his or her legally authorized representative, if any, that services should continue. Such efforts shall be documented in the client's record. If such efforts are unsuccessful, the Area Director or designee will request that the client or his or her legally authorized representative, if any, state in writing that the client no longer wants DMH continuing care services and will inform the client or his or her legally authorized representative, if any, that the individual will no longer be a client.
 - (c) The individual service plan shall be modified to indicate termination of services.
- (2) If a client disengages from DMH continuing care services without formal request or notification, efforts shall be made to re-engage the client. The mechanisms and time frame for such re-engagement efforts shall be a clinical decision. Such efforts shall be documented in the client's record.
- (a) When a clinical decision is made that re-engagement efforts have failed and are unlikely to succeed in the foreseeable future, the Area Director or designee shall be notified.
 - (b) If the Area Director or designee concurs, this shall be documented in the record and the individual will no longer be a client.
 - (c) The individual service plan shall be modified to indicate termination of services.
- (3) After an individual is determined not to be a client, the individual or his or her legally authorized representative, if any, may, in the future, reapply for DMH continuing care services if his or her circumstances change.

29.15: Appeals of Eligibility and Service Planning

- (1) General Provisions.
- (a) 104 CMR 29.15(3) contains the standards and procedures for appeals of denial or termination of eligibility based on clinical criteria pursuant to 104 CMR 29.04(3) .
 - (b) 104 CMR 29.15(4) contains the standards and procedures for appeals of denial of eligibility based on need for DMH continuing care services pursuant to 104 CMR 29.04(4), of major individual service planning and implementation decisions, of lowering of priority for DMH continuing care services pursuant to 104 CMR 29.12, and of termination of eligibility for DMH continuing care services pursuant 104 CMR 29.13.
 - (c) To the maximum extent possible, disagreements among the parties should be informally resolved prior to utilizing this appeal mechanism.
 - (d) An appeal on all appealable matters may be initiated by any of the following individuals:
 - 1. an individual who has been denied eligibility or whose priority for services has been lowered, or his or her legally authorized representative, if any;
 - 2. a client or his or her legally authorized representative, if any;
 - 3. a person designated by the individual or client to act as his or her representative, if there is no legally authorized representative.
- (2) Subject Matter of an Appeal. The following issues may be appealed:
- (a) whether denial of eligibility based on clinical criteria pursuant to 104 CMR 29.04(3) has a reasonable basis;
 - (b) whether denial of eligibility based on need for DMH continuing care services pursuant to 104 CMR 29.04(4) has a reasonable basis;
 - (c) whether the comprehensive assessment of service needs, the individual service plan, or the program specific treatment plans are consistent with the requirements of 104 CMR 29.06 through 29.08;
 - (d) whether the comprehensive assessment of service needs is sufficient to serve as the basis for the individual service plan or the program specific treatment plans;
 - (e) whether the comprehensive assessment of service needs, the individual service plan, or the program specific treatment plans have a reasonable basis;

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- (f) whether the service goals and objectives and timelines stated in the individual service plan or program specific treatment plan(s) are appropriate and reasonably related to the client's needs as identified in the application process or the comprehensive assessment of service needs;
- (g) whether the services identified in the comprehensive assessment of service needs, individual service plan or the program specific treatment plans are consistent with the client's needs, and provided in the least restrictive setting possible;
- (h) whether the individual service plan is being implemented in accordance with 104 CMR 29.00;
- (i) whether modification of an individual service plan, program specific treatment plan, services or change in service provider has a reasonable basis;
- (j) whether change in status to a lower priority pursuant to 104 CMR 29.12 has a reasonable basis;
- (k) whether termination of eligibility for DMH continuing care services pursuant to 104 CMR 29.13 has a reasonable basis;
- (l) whether the procedures set forth in 104 CMR 29.00 for developing the individual service plan and program specific treatment plan(s) have been followed.

(3) Appeal of Denial of Eligibility Based on Clinical Criteria. If an individual's application for eligibility for DMH continuing care services is denied by the Department based on clinical criteria, the denial may be appealed as follows:

- (a) Informal Conference. The individual or his or her legally authorized representative, if any, may request an informal conference with the Area Director or designee within ten days of receipt of the notice of the denial of application for eligibility based on clinical criteria. The individual or his or her legally authorized representative, if any, may bring other persons to this conference, if he or she wishes. After such meeting, if the issues are not resolved, the individual or his or her legally authorized representative, if any, shall be notified that a written request for reconsideration may be submitted to the Area Medical Director.
- (b) Request for Reconsideration. The individual or his or her legally authorized representative, if any, may submit a written notice of request for reconsideration to the Area Medical Director within ten days after conclusion of the informal conference. The request for reconsideration must indicate the basis of the request for reconsideration of the denial of the application, and may include any additional information which might support a reversal of the denial of application. The Area Medical Director shall render a written decision within ten days of the time he or she receives the request for reconsideration, unless the time is extended by mutual consent of the Area Medical Director and the person filing the request for reconsideration. If the denial of the application is not reversed by the Area Medical Director, a written decision letter shall be sent to the person who filed the request for reconsideration, and shall include notice of the right to pursue an appeal to the Deputy Commissioner for Clinical and Professional Services. If the denial of the application is reversed by the Area Medical Director, a written decision letter must be sent to the person who filed the request for reconsideration. Such decision will be final.
- (c) Notice of Appeal. The individual, or his or her legally authorized representative, if any, may submit a written notice of appeal to the Deputy Commissioner for Clinical and Professional Services within ten days of receipt of the written decision by the Area Medical Director affirming the denial of the application. This notice of appeal must indicate the basis of the appeal, and may include any additional information which might support a reversal of the denial of the application. The Deputy Commissioner shall render a decision within ten days from the time he or she receives the notice of appeal, unless an extension is agreed upon by mutual consent of the Deputy Commissioner and the person filing the appeal.
- (d) If the individual wishes to appeal from the Deputy Commissioner's decision, he or she may petition the Commissioner or designee for a fair hearing pursuant to 104 CMR 29.15(5).

(4) Appeal on All Other Appealable Matters.

- (a) An appeal is initiated by submitting a written statement to the Area Director, indicating what is being appealed and the basis for the appeal.

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(b) An appeal must be initiated within 30 days after the occurrence of the action or inaction which forms the basis for the appeal. The Area Director may, however, accept an appeal after 30 days for good cause.

(c) Informal Conference.

1. The Area Director or designee shall hold an informal conference with the client, the client's legally authorized representative, if any, the client's designated representative, if any, the client's case manager, the program director, if appropriate, and other invited persons, if appropriate, within 20 days of notification of the appeal for the purpose of resolving the matter being appealed. To the extent that resolution satisfactory to all persons is not achieved, the Area Director or designee shall clarify issues for appeal and shall determine the agreement, if any, of the parties as to the material facts of the case.

2. Except to the extent that statements of the parties are reduced to an agreed statement of facts, all statements of the parties made during the informal conference shall be considered as offers in compromise, and shall be inadmissible in any subsequent hearing or court proceedings pursuant to the provisions of 104 CMR 29.15.

3. The Commissioner or designee and the appealing party may agree to a waiver of the informal conference in which case the appeal shall go directly to a fair hearing pursuant to the provisions of 104 CMR 29.15(5).

(5) Fair Hearing. If an appealing party wishes to appeal from the Deputy Commissioner's decision with regard to clinical criteria pursuant to 104 CMR 29.15(3) or, if all other issues under appeal are not resolved at the informal conference pursuant to 104 CMR 29.15(4)(c), or there is a waiver of such conference, he or she may petition the Commissioner or designee for a fair hearing within ten days after the Deputy Commissioner's decision or completion or the waiver of the informal conference. Within ten days of such petition, the Commissioner shall appoint a hearing officer, who shall schedule a hearing date which is agreeable to both parties. Said fair hearing shall be conducted in a manner consistent with M.G.L. c. 30A and 104 CMR 29.15(5). Such hearing shall be governed by the informal fair hearing rules of the standard adjudicatory rules of practice and procedure at 801 CMR 1.02.

(a) While the appeal is pending, the parties may agree to implement any part of the individual service plan or program specific treatment plan or other matter under appeal without prejudice.

(b) The fair hearing shall be conducted by an impartial hearing officer designated by the Commissioner or designee.

(c) The appealing party shall have the right to be represented by an individual designated by him or her, at his or her own expense;

(d) If a client is unrepresented at the hearing but needs assistance, or if for any other reason the Commissioner or designee determines it to be in the client's best interest, the Commissioner or designee shall designate a client advocate to assist the client in the appeal.

(e) The appealing party and the Department shall have the right to present any evidence relevant to the issues under appeal, and shall have the right to call and examine witnesses.

(f) The appealing party shall have the right to examine all records held by the Department pertaining to the individual or client and all records upon which the individual service plan or program specific treatment plan is based.

(g) The fair hearing shall not be open to the public. The appealing party may invite persons of his or her choosing to attend. The hearing officer may also allow other persons to attend if he or she deems such attendance to be in the best interest of the client or other appealing party. Invited persons may attend the hearing, as long as they do not disturb the hearing.

(h) The hearing officer shall render a written decision within 20 days of the close of the hearing.

1. The decision shall include a concise statement of the facts found, a summary of the evidence relied upon, the decision and the reasons for so deciding and a notice of the right to petition the Commissioner or designee for a re-hearing pursuant to the provisions of 104 CMR 29.15(6) and to appeal the decision to the Superior Court under M.G.L. c. 30A, pursuant to 104 CMR 29.15(8).

2. The decision shall be mailed to the appealing party and his or her representatives, if any.

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3. Unless the Commissioner or designee orders a re-hearing, the decision of the hearing officer is the final decision of the Department on all issues.

(6) Re-hearing.

(a) Within ten days of receipt of the decision of the hearing officer by the client or his or her legally authorized representative, an appealing party may petition the Commissioner or designee to order a re-hearing on one or more of the following grounds:

- a. that new evidence was discovered by the appealing party subsequent to the hearing, and that the new evidence is such that it would be likely to materially affect the issues being appealed;
- b. that the hearing was conducted in a manner which was inconsistent with 104 CMR 29.15(5) or prejudicially unfair to the client or other appealing party;
- c. that the decision is based on inappropriate standards or contains other errors of law;
- d. that the decision is unsupported by any substantial evidence.

(b) The failure of the Commissioner or designee to grant or deny a petition for re-hearing within ten days of the submission of the petition shall be considered a denial of the petition.

(c) Upon order for a re-hearing by the Commissioner or designee, a hearing shall be conducted and a decision rendered anew, pursuant to the provisions of 104 CMR 29.15(5).

(7) Standard and Burden of Proof.

(a) The standard of proof on all issues shall be a preponderance of the evidence.

(b) Burden of Proof.

1. The burden of proof on the issue of denial of eligibility shall be on the individual who has been determined ineligible.
2. The burden of proof on the issues of whether the provisions of 104 CMR 29.06 through 104 CMR 29.11 have been complied with, and whether the comprehensive assessment of need, individual service plan, and program specific treatment plans are reasonable and consistent with the needs of the client shall be on the Department.
3. The burden of proof on issues relating to lowering of priority pursuant to 104 CMR 29.12 or termination of eligibility pursuant to 104 CMR 29.13 shall be on the Department.

(8) Judicial Review. A client or his or her legally authorized representative, if any, aggrieved by a final decision of the Department pursuant to 104 CMR 29.15 may, within 30 days of receipt of the decision or a decision after a re-hearing, seek judicial review of the decision, in accordance with the standards and procedures contained in M.G.L. c. 30A, § 14.

REGULATORY AUTHORITY

104 CMR 29.00: M.G.L. c. 19, §§ 1 and 16; c. 123, § 2.

(PAGES 399 THROUGH 424 ARE RESERVED FOR FUTURE USE).